



"People helping people help themselves"

Division of Mental Health and Addiction
 402 W. WASHINGTON STREET, ROOM W353
 INDIANAPOLIS, IN 46204-2739
 317-232-7800
 FAX: 317-233-3472

**Community-Based Options for Youth and Families
 Intensive Home and Community-Based Wraparound Services
 Non-Medical Transportation Service
 Provider Certification Form**

Date of Application:

Service Program (Check all that apply):
<input type="checkbox"/> PRTF Transition Waiver
<input type="checkbox"/> MFP-PRTF Demonstration Grant

Type of Provider (Check one):
<input type="checkbox"/> Accredited Agency
<input type="checkbox"/> Non-Accredited Agency
<input type="checkbox"/> Individual

Provider Information:

Name of Agency (if applicable):
Name of Applicant:

Phone number of person completing form:
Email of person completing form:

Agency Requirements (Check any that apply):

<i>Proof of Agency Status</i>
<input type="checkbox"/> Certification by the Division of Mental Health and Addiction (DMHA) as a Community Mental Health Center
<input type="checkbox"/> Approved accreditation by a nationally recognized accrediting body: AAAHC, COA, URAC, CARF, ACAC, JCAHO, OR NCQA
<input type="checkbox"/> Articles of Incorporation

Provider Criteria and Standards: Checking the items below is an acknowledgement that the staff member meets the required criteria and standards for this service:

<i>Clinical Requirements</i> Not Applicable
<i>Other Standards</i>
<input type="checkbox"/> Valid driver's license
<input type="checkbox"/> Individual has a safe driving record and a maintained vehicle (Confirmed by signed DMHA provider agreement)
<input type="checkbox"/> Current auto insurance on motor vehicle
<input type="checkbox"/> Current registration on motor vehicle
<input type="checkbox"/> Finger-print based national and state criminal history background screen*
<input type="checkbox"/> Local law enforcement screen*
<input type="checkbox"/> State and local Department of Child Services abuse registry screen*
<input type="checkbox"/> Five-panel drug screen, or Agency meets same requirements specified under the Federal Drug Free Workplace Act 41 U.S.C. 10 Section 702(a)(1)*
<i>Training</i>
<input type="checkbox"/> Provider Orientation Training
<input type="checkbox"/> Introduction to Systems of Care and Wraparound 101 Training
<input type="checkbox"/> CPR Certification

*Custodial parents, legal guardian and Foster Parent who is an Individual Provider does not have to provide proof of the indicated screens.

Note: DMHA will only process complete packets. All incomplete packets will be recycled. DMHA is responsible for verifying an agency meets the above qualifications initially and at renewal of license or accreditation.

Documentation Requirements:

<i>Submit copies of the documentation below, as indicated by the type of provider applying for certification</i>	Accredited Agency*	Non-Accredited Agency or Individual Provider
Provider Type Documentation:		
<input type="checkbox"/> CMHC Certification (If an Accredited Agency, submit a copy)	X	
<input type="checkbox"/> Proof of National Accreditation (If an Accredited Agency, submit a copy)	X	
<input type="checkbox"/> Articles of Incorporation (If a Non-Accredited Agency, submit a copy)		X
Clinical Documentation:		
Not Applicable	NA	NA
Other Standards Documentation:		
<input type="checkbox"/> Finger-print based national and state criminal history background screen results**†	X	X
<input type="checkbox"/> Local law enforcement screen results†	X	X
<input type="checkbox"/> State and local Department of Child Services abuse registry screen results†	X	X
<input type="checkbox"/> Five-panel drug screen results (<i>Not applicable if Agency meets same requirements specified under the Federal Drug Free Workplace Act</i>) †	X	X
Training Documentation:		
<input type="checkbox"/> Provider Orientation Training (Copy of certificate)	X	X
<input type="checkbox"/> Introduction to Systems of Care and Wraparound 101 Training (Copy of certificate)	X	X
<input type="checkbox"/> CPR Certification (Copy of certificate)	X	X
Miscellaneous Documentation:		
<input type="checkbox"/> Provider Demographic Form (Signed original)	X	X
<input type="checkbox"/> Provider Agreement (Signed original)	X	X
<input type="checkbox"/> Valid Driver's License (Copy)	X	X
<input type="checkbox"/> Current auto insurance card or proof of current coverage (Copy)	X	X
<input type="checkbox"/> Proof of vehicle registration (Copy)	X	X

****Accredited Agency Note:** *The provider agency must maintain documentation that Applicant meets the required criteria and standards for the Non-Medical Transportation service; and have records available for DMHA to complete quality review audits.*

† *Custodial parents, legal guardian and Foster Parent who is an Individual Provider does not have to provide proof of the indicated screens.*

Failure to provide documentation for DMHA inspection may result in corrective action up to and including decertification of agency.

Return completed forms and required documentation to DMHA:

Division of Mental Health and Addiction
 Attn: Community-Based Options for Youth & Families Team
 402 W Washington St., W353
 Indianapolis, IN 46204-2739

Policy/Procedure Approval		
Revised: April 2013	Non-Medical Transportation Certification Form	
OMPP Approval:	On file	Date: April 2013
DMHA Approval:	On file	Date: April 2013